Ryan White Enrollment Application - Secondary Dental Services

Secondary Dental serves individuals with medical insurance but no dental insurance.
Individuals with no medical insurance should be enrolled in Ryan White Primary Care using form RW-1.
Clients will be registered only with the submission of this fully completed form and required supporting documentation.

PRINT

Last Name	**First Name**	**MI**	**Social Security #**	**Mother's Maiden Name**

Date of Birth	**Gender:** ☐**M** ☐**F** ☐**MTF** ☐**FTM**	**Housing Status** ☐Rent; ☐Own; ☐Rent room; ☐Live with family/ friends; ☐Substance Abuse Treatment Facility; ☐Assisted Living Facility; ☐Homeless

Hispanic? ☐Yes; ☐No	**Race:** ☐White; ☐Black; ☐Asian; ☐American Indian/Native Alaskan; ☐Pacific Islander; Other: _____

Home Address	**City**

ZIP	**County**	**Phone #** Include Area Code	**Gross monthly income $**	**Household Size**

HIV/AIDS Status: ☐HIV positive, disease stage unknown; ☐HIV positive, asymptomatic; ☐HIV positive symptomatic, not AIDS; ☐HIV positive, disabling; ☐CDC-Defined AIDS; ☐Disabling AIDS	**Year Status Effective**

HIV/AIDS status documentation: ☐Letter of Diagnosis; ☐Medical Record; ☐Lab Results	**Mode of Transmission:** ☐Homosexual/Bisexual; ☐Heterosexual; ☐IDU; ☐Blood Trans/Hemophilia; Other:

1. Other Coverage/Insurance

a. Does client currently have Medi-Cal (Denti-Cal) coverage or dental insurance? ☐Yes ☐No (If "No" go to 1d)

b. If 1a is "Yes", Name of insurer: _____ Exp: _____
Member # _____
Copy both sides of the insurance card and retain with this application.

c. If 1a is "Yes", is this procedure covered by Denti-Cal or insurance? ☐Yes ☐No
If 1c is "Yes", STOP; the individual is not eligible for Secondary Dental for this procedure.
If 1c is "No", **attach the denial notice from the insurance carrier** (not needed for Denti-Cal).

d. Medical insurer/coverage _____
Member # _____ End Date _____
Copy both sides of the insurance card and retain with this application.

2. Eligibility (The following are program requirements; indicate completion by checkmark prior to faxing this form to AmeriChoice.)

☐ Response to 1a is "No" and 1d is completed or 1a is "Yes" and 1c is "No".

☐ HIV/AIDS status documentation has been provided and a copy is retained with this application.

☐ Applicant has signed the ARIES Client Consent Form and a copy is retained with this application.

☐ Applicant has provided his/her insurance card and a copy is retained with this application.

☐ Applicant has provided a denial letter and a copy is retained with this application.

All information on this form is accurate to the best of my knowledge.

Client Signature: _____ Date: _____

Staff completing this form: _____
Name/Title

_____ (_____) _____
Agency/Clinic Phone Number

Submit this completed application and denial notice (if applicable) to AmeriChoice via fax number (858) 495-1329